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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2023

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A N A C T

RELATING TO INSURANCE -- INSURANCE COVERAGE FOR PREVENTION OF HIV INFECTION

Introduced By: Senators Murray, Valverde, Lauria, Pearson, Euer, Lawson, Mack, Acosta, Miller, and Cano
Date Introduced: March 07, 2023

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Title 27 of the General Laws entitled "INSURANCE" is hereby amended by adding thereto the following chapter:

CHAPTER 38.3

INSURANCE COVERAGE FOR PREVENTION OF HIV INFECTION

27-38.3-1. Coverage for prevention of HIV infection.

(a) A group health plan and an individual or group health insurance plan shall provide coverage for the prevention treatment of HIV infection under the same terms and conditions as that coverage is provided for other illnesses and diseases.

(b) Coverage for the prevention treatment of HIV infection shall not impose any annual or lifetime dollar limitation.

(c) Financial requirements and quantitative treatment limitations on coverage for the prevention treatment of HIV infection shall be no more restrictive than the predominant financial requirements applied to substantially all coverage for medical conditions in each treatment classification.

(d) Coverage shall not impose non-quantitative treatment limitations for the prevention treatment of HIV infection unless the processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary

standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

(e) The following classifications shall be used to apply the coverage requirements of this chapter:

(1) Inpatient, in-network;

(2) Inpatient, out-of-network;

(3) Outpatient, in-network;

(4) Outpatient, out-of-network;

(5) Emergency care; and

(6) Prescription drugs.

(f) Payors shall rely upon the criteria of the Society of Infectious Diseases Pharmacists when developing coverage for levels of care for HIV prevention treatment.

27-38.3-2. Definitions.

As used in this section, unless the context otherwise indicates, the following terms have the following meanings:

(1) "CDC guidelines" means guidelines related to the nonoccupational exposure to potential HIV infection, or any subsequent guidelines, published by the federal Department of Health and Human Services, Centers for Disease Control and Prevention.

(2) "Financial requirements" means deductibles, copayments, coinsurance, or out-of-pocket maximums.

(3) "Group health plan" means an employee welfare benefit plan as defined in 29 U.S.C. § 1002(1) to the extent that the plan provides health benefits to employees or their dependents directly or through insurance, reimbursement, or otherwise. For purposes of this chapter, a group health plan shall not include a plan that provides health benefits directly to employees or their dependents, except in the case of a plan provided by the state or an instrumentality of the state.

(4) "Health insurance plan" means health insurance coverage offered, delivered, issued for delivery, or renewed by a health insurer.

(5) "Health insurers" means all persons, firms, corporations, or other organizations offering and assuring health services on a prepaid or primarily expense-incurred basis, including, but not limited to, policies of accident or sickness insurance, as defined by chapter 18 of this title; nonprofit hospital or medical service plans, whether organized under chapter 19 or 20 of this title or under any public law or by special act of the general assembly; health maintenance organizations, or any other entity that insures or reimburses for diagnostic, therapeutic, or preventive services to a determined population on the basis of a periodic premium. Provided, this chapter does not apply to

insurance coverage providing benefits for:

(i) Hospital confinement indemnity;

(ii) Disability income;

(iii) Accident only;

(iv) Long-term care;

(v) Medicare supplement;

(vi) Limited benefit health;

(vii) Specific disease indemnity;

(viii) Sickness or bodily injury or death by accident or both; and

(ix) Other limited benefit policies.

(6) "HIV prevention drug" means a preexposure prophylaxis drug, post-exposure prophylaxis drug or other drug approved for the prevention of HIV infection by the federal Food and Drug Administration.

(7) "Non-quantitative treatment limitations" means:

(i) Medical management standards;

(ii) Formulary design and protocols;

(iii) Network tier design;

(iv) Standards for provider admission to participate in a network;

(v) Reimbursement rates and methods for determining usual, customary, and reasonable charges; and

(vi) Other criteria that limit scope or duration of coverage for services in the prevention treatment of HIV infection, including restrictions based on geographic location, facility type, and provider specialty.

(8) "Post-exposure prophylaxis drug" means a drug or drug combination that meets the clinical eligibility recommendations provided in CDC guidelines following potential exposure to HIV infection.

(9) "Preexposure prophylaxis drug" means a drug or drug combination that meets the clinical eligibility recommendations provided in CDC guidelines to prevent HIV infection.

(10) "Quantitative treatment limitations" means numerical limits on coverage for the preventive treatment of HIV infection based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment.

27-38.3-3. Coverage required.

A health insurer offering a health plan in this state shall provide coverage for an HIV prevention drug that has been prescribed by a provider. Each long-acting injectable drug with a

different duration shall constitute a separate method of administration. Coverage under this section is subject to the following:

(1) If the federal Food and Drug Administration has approved one or more HIV prevention drugs that use the same method of administration, a health insurer is not required to cover all approved drugs as long as the insurer covers at least one approved drug for each method of administration with no out-of-pocket cost.

(2) A health insurer is not required to cover any preexposure prophylaxis drug or post-exposure prophylaxis drug dispensed or administered by an out-of-network pharmacy provider unless the enrollee's health plan provides an out-of-network pharmacy benefit.

(3) A health insurer shall not prohibit or permit a pharmacy benefits manager to prohibit a pharmacy provider from dispensing or administering any HIV prevention drugs.

27-38.3-4. Limits on prior authorization and step therapy requirements.

Notwithstanding any requirements to the contrary, a health insurer shall not subject any HIV prevention drug to any prior authorization or step therapy requirement except as provided in this section. If the federal Food and Drug Administration has approved one or more methods of administering HIV prevention drugs, an insurer is not required to cover all of the approved drugs without prior authorization or step therapy requirements as long as the insurer covers at least one approved drug for each method of administration without prior authorization or step therapy requirements. If prior authorization or step therapy requirements are met for a particular enrollee with regard to a particular HIV prevention drug, the insurer is required to cover that drug with no out-of-pocket cost to the enrollee.

27-38.3-5. Coverage for laboratory testing related to HIV prevention drugs.

A health insurer offering a health plan in this state shall provide coverage with no out-of-pocket cost for any ancillary or support service determined by the department of health that is necessary to:

(1) Ensure that such a drug is prescribed and administered to a person who is not infected with HIV and has no medical contraindications to the use of such drug; and

(2) Monitor such a person to ensure the safe and effective ongoing use of such a drug through:

(i) An office visit;

(ii) Laboratory testing;

(iii) Testing for a sexually transmitted infection;

(iv) Medication self-management and adherence counseling; or

(v) Any health service specified as part of comprehensive HIV prevention drug services by

the United States Department of Health and Human Services, the United States Centers for Disease Control and Prevention or the United States Preventive Services Task Force.

27-38.3-6. Medical necessity and appropriateness of treatment.

(a) Upon request of the reimbursing health insurers, all providers of prevention treatment of HIV infection shall furnish medical records or other necessary data which substantiates that initial or continued treatment is at all times medically necessary and/or appropriate. When the provider cannot establish the medical necessity and/or appropriateness of the treatment modality being provided, neither the health insurer nor the patient shall be obligated to reimburse for that period or type of care that was not established. Exception to the preceding requirement can only be made if the patient has been informed of the provisions of this subsection and has agreed in writing to continue to receive treatment at their own expense.

(b) The health insurers, when making the determination of medically necessary and appropriate treatment, shall do so in a manner consistent with that used to make the determination for the treatment of other diseases or injuries covered under the health insurance policy or agreement.

(c) Any subscriber who is aggrieved by a denial of benefits provided under this chapter may appeal a denial in accordance with the rules and regulations promulgated by the department of health pursuant to chapter 17.12 of title 23.

27-38.3-7. Network coverage.

The healthcare benefits outlined in this chapter apply only to services delivered within the health insurer's provider network; provided that, all health insurers shall be required to provide coverage for those benefits mandated by this chapter outside of the health insurer's provider network where it can be established that the required services are not available from a provider in the health insurer's network.

SECTION 2. This act shall take effect on January 1, 2024.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO INSURANCE -- INSURANCE COVERAGE FOR PREVENTION OF HIV INFECTION

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This act would require coverage for the treatment of pre-exposure prophylaxis (PrEP) for the prevention of HIV and post-exposure prophylaxis (PEP) for treatment of HIV infection, commencing January 1, 2024.

This act would take effect on January 1, 2024.

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